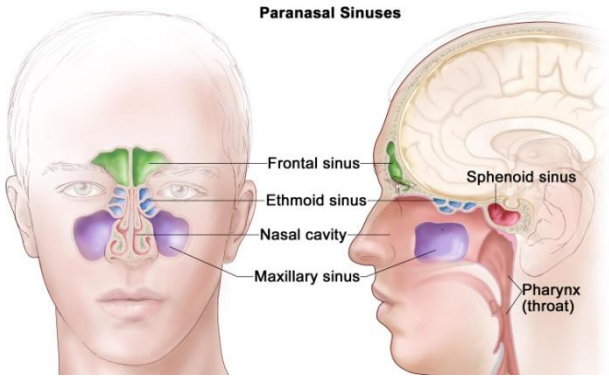
Name _____ DOB _____

RHINOSINUSITIS SYMPTOM INVENTORY (RSI)

Please, rate the following individual items based on your AVERAGE symptoms over the previous 3 months.
Symptoms that are not present or have been present for <3 months should not be rated.
Please, check the appropriate box for each item.

SYMPTOMS	NOW	3 MONTHS OR MORE
Facial Pain/Pressure		
Facial Congestion/Fullness		
Nasal Obstruction/Blockage		
Discoloration or Pus Nasal Drainage or Post Nasal Drip		
Decreased Sense of Smell		
Headaches		
Fevers		
Halitosis (Bad Breath)		
Fatigue (Tiredness)		
Dental Pain		
Cough		
Ear Pain/Pressure		
Nosebleeds		
Sleep Apnea		
Previous Nasal Surgery		



Please, indicate on the facial map where you are experiencing facial pressure, discomfort, or pain.

Please, circle the area(s) of concern.

Please, label the circle(s) accordingly:

D = Discomfort

P = Pain

X = Pressure

Nasal Steroid Sprays I have used these medications for 3 months or more _____ Yes _____ No

If yes, please circle or list the medication: Vancensase, Beconase, Nasonex, Nasocort, Flonase, _____

Anti-Histamines I have used these medications for 3 months or more _____ Yes _____ No

If yes, please circle or list the medication: Allegra, Claritin, Zyrtec, _____

Antibiotics I have used these medications for 3 months or more _____ Yes _____ No

Number of courses in the past 3 months _____

Names of Antibiotics 1. _____ 2. _____ 3. _____

Please, comment on how the nasal problem has affected your work/social status as listed below:

In the past 12 months, I missed a total of _____ days or work/school due to nasal problems.

In the last 12 months, I have had _____ acute infections of my nose/sinus.

Patient Signature _____ Date _____